



<b>Organization Name:</b>	<b>Program Name:</b>	
<b>Individual's Name (First MI Last):</b>	<b>Record #:</b>	<b>DOB:</b>

**Military Service History**

Who is or has been in the US Armed forces?	
When did the service member serve?	
What military branch?	<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserves/National Guard Other:
What was/is their job in the military?	
Has the service member registered at the VA?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Have there been challenges around benefits or entitlements? <i>If so, refer to the local Veterans Service Agency</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Is the service member currently deployed?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
If so, when is the anticipated date of return?	
Is deployment pending or imminent?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
How many deployments have occurred and for what duration?	
Has anyone in your family sought treatment for psychological distress related to military services?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:

**Military Family/Significant Other Screen**

Do you have concerns around seeking help or impact on the service members' career?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Describe the impact deployment or service has had on you and/or the family (emotional/physical).	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Has the family relocated because of service?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Does the service member or family members have difficulty with mood changes, depression, irritability or anger management?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Is there any violence at home (e.g., anyone being hit)?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Are there any difficulties with renegotiating roles and tasks?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Did you ever think that your loved one could be seriously injured or killed?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Does the service member or family members know anyone that was seriously injured or killed?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Did the service member share stories or did others overhear statements involving death or serious injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Is the service member or significant other experiencing flashbacks or reliving of traumatic events?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Are there known triggers ( <i>identify sights, sounds, smells, situations</i> ) that the service member or others identified?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Is there any screaming during the night due to nightmares or difficulty coping?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Is anyone in the household experiencing frequent thoughts of death, suicide or homicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Does the service member or others sleep with weapons?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:



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**Couples**     Not Applicable

Are there difficulties with intimacy or sexual functioning?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are there known issues of infidelity or emotional separation?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do you and your partner need skill building with problem solving or conflict resolution?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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**Children**     Not Applicable

Are there behavior problems in school or home?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Has the child witnessed or experienced uncontrollable outbursts?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are there any difficulties with bonding, attachment or connection?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Were significant milestones missed or impacted (birthdays, graduations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do the school social worker and teacher know the child is from a military family?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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**Clinical Formulation**

<b>Completed By - Print Name/Credentials:</b>	<b>Staff Signature:</b>	<b>Date:</b>
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<b>Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed)::</b>	<b>Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed):</b>	<b>Date:</b>
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